COMPREHENSIVE
INSURANCE
SERVICES

Quick Check

Comprehensive Insurance Services, LLC

6975 SW Sandburg St. Suite 290 Tigard Or. 97223-8071
Phone: (503) 684-8333 or (888) 699-9860 Fax: (503) 684-5665 email: cis@cispdx.com

PRELIMINARY INQUIRY – NOT AN APPLICATION FOR LIFE INSURANCE

PERSONAL HISTORY

Name ____________________ ☐ Male ☐ Female SS# ____________

Address ____________________ City __________ State ______ Zip ______

Date of Birth ______________ Driver License # __________ Phone __________

Tobacco Use: None _____ Cigarettes _____ Other ____________ Occupation __________

PLAN AND AMOUNT

Face Amount ____________________ Plan: ☐ UL ☐ Whole Life ☐ Term ☐ Survivorship

For Survivorship, Spouse Date of Birth ____________________ ☐ Smoker ☐ Non-Smoker

Is the insurance applied for to replace insurance? ☐ Yes ☐ No

AGENT INFORMATION

Agent Name ____________________ SS# ______________ Phone __________
Address ____________________ City ______________ State ______ Zip ______

Additional Notes

PLEASE PRINT

Medical Questions Provide details to "Yes" answers in the space below

1. Have 2 or more of your immediate family members (parents, brothers and sisters) died before the age of 65 or been diagnosed before the age of 65, with coronary artery disease, stroke or kidney disease? ☐ Yes ☐ No If "Yes" give details:

2. Family History	LIVING	Age	Give Details of Parental Health	DECEASED	Age	Cause of Death
Father						
Mother						
Brothers and Sisters						

3a. Your Height ____________________ 3b. Your Weight ____________________ 3c. Any weight loss in the last year? ☐ Yes ☐ No

4a. Name and address of personal or attending doctor.
____
____
____

4b. Date last consulted ________________________________

4c. Reason and any medication/treatment given __________________
____
____

4d. List any medications you are taking currently ____

5.	**So far as you know, within the last 10 years have you had or been told by a doctor that you had:**	**Yes**	**No**
a.	Chest pain, shortness of breath, heart murmur, high blood pressure, stroke, irregular heart beat, or any other disease or disorder of the heart or arteries?	☐	☐
b.	Diabetes or disease of any glands?	☐	☐
c.	Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system?	☐	☐
d.	Arthritis, gout, or any bone, joint, muscle or skin disorder?	☐	☐
e.	Asthma, bronchitis, pneumonia, emphysema or any lung disorder?	☐	☐
f.	Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, or other disease of the liver, gall bladder, pancreas, stomach or intestines?	☐	☐
g.	Prostate or testicular disease, disease of the uterus, ovaries or breasts?	☐	☐
h.	Anemia, leukemia, clotting disorders, platelet disorders, infections or sources of blood loss?	☐	☐
i.	Disorder of the urinary tract or kidneys, sugar, albumin or blood in the urine?	☐	☐
j.	Cancer or tumors?	☐	☐
k.	An operation or admission to a hospital or any other health care facility, for observation, treatment of any illness or diagnostic tests, including treadmill stress test for insurance?	☐	☐
l.	Any other health impairment or medically treated condition?	☐	☐
m.	Treatment or advice from a physician, licensed practitioner or any organization regarding alcohol or drug use?	☐	☐
n.	Within the last 10 years have you been diagnosed by a doctor s having Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐

PLEASE PROVIDE DETAILS TO ANY "YES" ANSWERS (If more space is required, use an additional sheet)

Question Number	Date	Reason and any Treatment given	Duration of Condition	Name Address and Phone No. of Attending Doctor and Hospital

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Name_______________________________________DOB__________SS#___________

Comprehensive Insurance Services, LLC ~ Advanced Settlements, Inc. ~ American General ~ AXA Equitable
Coventry First ~ John Hancock ~ Aviva ~ ING ~ Lincoln Benefit Life ~ Lincoln Financial ~ Protective Life
Metropolitan Life ~ Met Life Investors USA ~ Prudential Financial ~ Reliastar ~ Security Life of Denver
Sun Life ~ Transamerica Life Insurance Co. ~ United of Omaha ~ Mutual of Omaha ~ West Coast Life

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

I understand that any company named above, its reinsurers, any support organizations and those persons authorized to represent them may need to collect medical information on me in regard to proposed insurance coverage. I understand that the information obtained will be used: (a) to underwrite my application for coverage; (b) make eligibility, risk rating, policy issuance and enrollment determinations; (c) obtain insurance; (d) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (e) administer coverage; and/or (f) conduct other legally permissible activities that relate to any coverage I have or have applied for.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB, Inc.) or other health care provider that has provided payment, treatment or services to me or on my behalf or to or on the behalf of my unemancipated minor children (My Providers") to disclose the entire medical record and any other protected health information concerning me or my unemancipated minor children to the company(ies) referenced on this authorization ("the Company(ies)") and its agents, employees, and representatives (such as EMSI, J&H Copy Services, Portamedic). This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted disease. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

The types of information will include facts about my: (1) mental and physical health, (2) other insurance coverage, (3) hazardous activities, (4) character, (5) general reputation, (6) mode of living, (7) finances, (8) occupation, and (9) other personal traits. I further understand that the specific type of information to be re-disclosed may, if applicable, include diagnosis, prognosis, and treatment for any physical, emotional illness and/or serious communicable disease/ infection, including sexually transmitted diseases.

Those parties named in the first paragraph of this Authorization may disclose the information that they have collected. They may disclose this information to: (1) other insurers to which I have applied or may apply, (2) reinsurers, (3) MIB, or (4) other persons who perform business, professional, or insurance tasks for them. They may also disclose this information as may be allowed or required by law.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information or that of my unemancipated minor children do not apply to this authorization and I instruct my providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this authorization at my request, as permitted by § 164.508©(1)(iv) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

This Authorization will be valid for 180 days following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the CIS. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. I understand that a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that CIS has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulation governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, CIS will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policy.

I understand that my providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record or that of my unemancipated minor children, CIS may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signed at____ on ____/____/______

x_______________________________________ _______________________________________
Signature of Proposed Insured — Signature of Personal Representative

____
Relationship to Proposed Insured

Revised 04/11